

**Memorandum**

Date DEC 12 1994

From June Gibbs Brown
Inspector General *June G Brown*

Subject Review of Ambulatory Surgical Services Performed in Hospital Outpatient Departments -
Procedure Coding Differences (A-01-94-00507)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached is a copy of our final report entitled, "Review of Ambulatory Surgical Services Performed in Hospital Outpatient Departments - Procedure Coding Differences." The objective of our review was to determine if coding differences exist between hospital outpatient departments (OPD) and physicians in the procedure coding of ambulatory surgeries and whether these differences have a significant effect on the Medicare program.

The Health Care Financing Administration (HCFA), after consulting with appropriate medical organizations, specified a list of surgical procedures that may be performed safely on an ambulatory basis. Derived from the Physicians' Current Procedural Terminology, Fourth Edition is the specified list of surgical procedures used by OPDs and physicians in the coding of ambulatory surgical procedures. Reimbursement to OPDs and physicians is based on procedure code.

The financial integrity of the Medicare program is dependent upon accurate coding of rendered medical services. When a beneficiary undergoes an ambulatory surgery, e.g., cataract surgery, one would expect both the OPD and the physician to bill for the same procedure. Yet, in Region I, a 23 percent rate of inconsistency exists between the OPD's procedure code and the physician's procedure code for the same ambulatory surgery. Additional analysis showed a similar rate of inconsistency exists nationwide.

The procedure coding differences have an immediate and future effect on the Medicare program. First, a significant number of incorrect payments (overpayments and/or underpayments) to both OPDs and/or physicians are made. Second, beneficiaries are making incorrect payments of their 20 percent coinsurance. Finally, data which HCFA may utilize in developing future reimbursement rates are inaccurate.

Page 2 - Bruce C. Vladeck

The procedure coding differences happen primarily because (1) ineffective communication/coordination exists between OPDs and physicians; and (2) the present Medicare medical review structure does not provide a focal point, i.e., the Peer Review Organizations (PRO), for an encompassing review of OPDs' and physicians' services.

Before these causes can be addressed, procedure coding differences need to be identified on an ongoing basis. Presently, there is no edit in place either at the intermediary/carrier level or at the Common Working File level to identify these differences. We acknowledge that HCFA is planning to replace current claims processing systems with the Medicare Transaction System (MTS), a single integrated claims processing system. While the MTS is under development, consideration should be given to designing the necessary edits for identifying coding differences.

We recommend that HCFA consider three measures to address procedure coding differences. First, until such time as the MTS is phased in, foster coordination/communication between providers so that procedure coding differences are identified prior to submission of claims. This could be achieved by requiring an attestation as to the procedure performed. Second, require PROs to review the entire episode of care, i.e., OPD claims and physician claims, for pattern analyses. Finally, design an edit for the MTS to identify procedure coding differences between OPD and physician claims and to generate a notice to OPDs and physicians informing them that procedure coding differences have been identified.

In response to our draft report, HCFA concurred with the intent of our first recommendation, and concurred with our third recommendation. However, HCFA nonconcurred with our second recommendation citing that screening of unified claims files with intermediary or carrier medical review should be substituted for PRO review. The HCFA's comments are presented in the appendix to this report and are addressed on pages 9 and 10.

Please advise us within 60 days on actions taken or planned on our recommendations. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits at (410) 966-7104. Copies of this report are being sent to other interested Department officials.

To facilitate identification, please refer to Common Identification Number A-01-94-00507 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF
AMBULATORY SURGICAL SERVICES
PERFORMED IN HOSPITAL
OUTPATIENT DEPARTMENTS -
PROCEDURE CODING DIFFERENCES**



JUNE GIBBS BROWN
Inspector General

DECEMBER 1994
A-01-94-00507

S U M M A R Y

BACKGROUND

The Health Care Financing Administration (HCFA), after consulting with appropriate medical organizations, specified a list of surgical procedures that may be performed safely on an ambulatory basis. Derived from the Physicians' Current Procedural Terminology, Fourth Edition (CPT-4) is the specified list of surgical procedures used by hospital outpatient departments (OPD) and physicians in the coding of ambulatory surgical procedures. Reimbursement to OPDs and physicians is based on procedure code.

Intermediaries process outpatient claims for ambulatory surgical services submitted by OPDs. Carriers are responsible for the review and approval of services by physicians covered under the Medicare Part B program.

In Fiscal Years (FY) 1991 and 1992, reimbursement for hospital outpatient ambulatory surgeries amounted to \$1.2 billion and \$1.3 billion, respectively, nationwide.

OBJECTIVE

The objective of our review was to determine if coding differences exist between OPDs and physicians in the procedure coding of ambulatory surgeries and whether these differences have a significant effect on the Medicare program. The period covered by our review included ambulatory surgery claims validated by the Peer Review Organizations (PRO) in Region I during the period January 1, 1993 through September 30, 1993.

RESULTS

The financial integrity of the Medicare program is dependent upon accurate coding of rendered medical services. When a beneficiary undergoes an ambulatory surgery, e.g., cataract surgery, one would expect both the OPD and the physician to bill for the same procedure. Yet, in Region I, a 23 percent rate of inconsistency exists between the OPD's procedure code and the physician's procedure code for the same ambulatory surgery (see Figure 1). Additional analysis showed a similar rate of inconsistency exists nationwide.

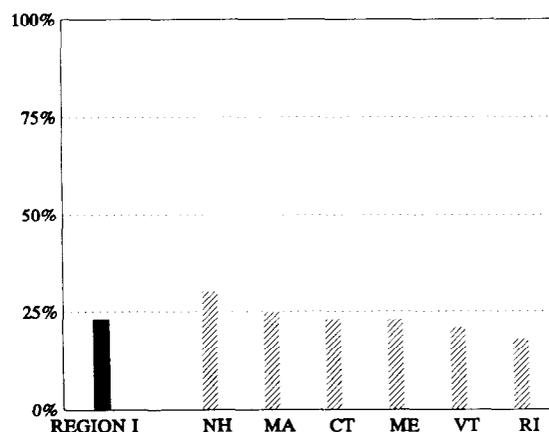


Figure 1 - Rate of Procedure Coding Differences

The procedure coding differences have an immediate and future effect on the Medicare program. First, a significant number of incorrect payments (overpayments and/or

underpayments) to both OPDs and/or physicians are made. Second, beneficiaries are making incorrect payments of their 20 percent coinsurance. Finally, data which HCFA may utilize in developing future reimbursement rates are inaccurate.

For the cases reviewed, the coding differences occur among all specialties but are more prevalent among General Surgery, Gastroenterology, and Urology. The procedure coding differences happen primarily because:

- ▶ ineffective communication/coordination exists between OPDs and physicians; and
- ▶ the present Medicare medical review structure does not provide a focal point, i.e., the PROs, for an encompassing review of OPDs' and physicians' services.

Before these causes can be addressed, procedure coding differences need to be identified on an ongoing basis. Presently, there is no edit in place either at the intermediary/carrier level or at the Common Working File (CWF) level to identify these differences. We acknowledge that HCFA is planning to replace current claims processing systems with the Medicare Transaction System (MTS), a single integrated claims processing system. While the MTS is under development, consideration should be given to designing the necessary edits for identifying procedure coding differences.

RECOMMENDATIONS

We are recommending that HCFA implement the following:

- 1) Until such time as the MTS is phased in, foster coordination/communication between providers so that procedure coding differences are identified prior to submission of claims. This could be achieved by requiring an attestation as to the procedure performed.
- 2) Require PROs to review the entire episode of care, i.e., OPD claims and physician claims, for pattern analyses.
- 3) Design an edit for the MTS to identify procedure coding differences between OPD and physician claims and to generate a notice to OPDs and physicians informing them that procedure coding differences have been identified.

In response to our draft report, HCFA concurred with the intent of our first recommendation, and concurred with our third recommendation. However, HCFA nonconcurred with our second recommendation citing that screening of unified claims files with intermediary or carrier medical review should be substituted for PRO review. The HCFA's comments are presented in the appendix to this report and are addressed on pages 9 and 10.

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INTRODUCTION

BACKGROUND

Since the inception of the prospective payment system for inpatient hospital services, there has been a shift from inpatient care to outpatient care, especially for surgical services. As such, sections 1832(a)(2)(F)(i) and 1833(i)(1)(A) of the Social Security Act (the Act) provides for Medicare Part B coverage of facility services furnished in connection with surgical procedures performed safely in an independent ambulatory surgical center (ASC) or an OPD. In FY 1991 and 1992, reimbursement for hospital outpatient ambulatory surgeries amounted to \$1.2 billion and \$1.3 billion, respectively, nationwide.

The HCFA, after consulting with appropriate medical organizations, specified a list of surgical procedures that may be performed safely on an ambulatory basis. The Medicare Carriers Manual includes the list of covered procedures using the specific procedure codes from the CPT-4. The CPT-4 is a systematic listing and coding of procedures and services performed by physicians. Section 9343(g) of the Omnibus Budget Reconciliation Act (OBRA) of 1986 states that OPDs must report outpatient services provided to Medicare beneficiaries using the HCFA Common Procedure Coding System (HCPCS). The HCFA developed HCPCS by using the American Medical Association's CPT-4 for physician services. Hospitals use the CPT-4 portion of HCPCS to report significant outpatient surgical procedures.

Reimbursement to OPDs and physicians is based on procedure code. For OPD reimbursement:

- ▶ All ambulatory surgical procedures are classified into nine payment groups.
- ▶ All procedures within the same group are assigned an ASC payment amount equal to a prospectively determined payment rate established by HCFA for a procedure furnished by an independent ASC in the same geographic area. Currently, the amounts range from \$295 to \$1,150.
- ▶ For cost settlement, section 1833(i)3(A)(B) of the Act states the aggregate amount of payments for facility services furnished in an OPD for covered ASC surgical procedures is equal to the lower of the reasonable cost, customary charges, or the blended amount (the blended amount is based on hospital-specific cost and charge data and an ASC payment amount).

For physician reimbursement:

- ▶ Section 1848(a)(1) of the Act requires that payment be made under a physician fee schedule.

The Federal Government contracts with private insurance organizations called intermediaries and carriers to process claims and make Medicare payments. Intermediaries process outpatient claims for ambulatory surgical services submitted by OPDs. Carriers are responsible for the review and approval of services by physicians covered under the Medicare Part B program. Both intermediaries and carriers use the CWF as a prepayment validation system to avoid improper payments. The HCFA has plans to replace the Medicare contractors' claims processing systems and CWF with the MTS. The MTS will be a single, national, standard and integrated claims processing system for both Medicare Part A and Part B claims. The MTS will allow HCFA to take advantage of the cost effectiveness of one system both in its design and maintenance.

The Federal Government also contracts with PROs to review the care given to Medicare beneficiaries. The PROs are required to review services furnished by physicians, other health care professionals, and providers performed either in an independent ASC or an OPD setting to ensure proper procedure coding. Section 1154(d) of the Act requires the PROs' review process to include a review of procedures on HCFA's ASC procedure code list. The HCFA selects and provides the PROs with a random sample of ambulatory surgical cases performed in OPDs for which they:

- ▶ review each procedure performed for medical necessity;
- ▶ determine the quality of rendered care;
- ▶ determine if the procedure was provided in the proper setting; and
- ▶ perform coding validation of the CPT-4/HCPCS codes.

SCOPE

Our review was made in accordance with generally accepted government auditing standards. The objective of our review was to determine if coding differences exist between OPDs and physicians in the procedure coding of ambulatory surgeries and whether these differences have a significant effect on the Medicare program. Our audit covered ambulatory surgeries reviewed by Region I PROs during the period January 1, 1993 through September 30, 1993.

We limited the consideration of the internal control structure because the objective of our review did not require an understanding or assessment of the internal control structure at intermediaries, carriers, or PROs in Region I. Our review of the internal control structure was limited to obtaining an understanding of how claims for ambulatory surgical services are reviewed and coded.

To accomplish our objective, we:

- ▶ obtained 2,591 validated ambulatory surgery claims reviewed by the PROs in Region I for the period in our audit;
- ▶ randomly selected 629 cases from Region I states with Calendar Year (CY) 1993 service dates;

- ▶ obtained the beneficiary histories associated with those physician services with CY 1993 service dates from the carriers;
- ▶ compared the validated ambulatory surgery claims performed in OPDs with CY 1993 service dates with the beneficiary histories obtained from the carrier; and
- ▶ asked the PROs for possible explanations as to why an inconsistency exists between OPDs' coding of ambulatory surgery and physicians' coding of the same ambulatory surgery exists for the cases we identified.

To determine the extent of procedure coding differences on a nationwide basis, we conducted a computer match utilizing HCFA's Medicare Part A Paid Claims File and the National Claims History 5 Percent File. We used the most current data available at that time which was the period January 1991 through December 1992. We did not examine this data in the same manner as the data obtained from the PROs.

In addition, selected Boston area hospitals and physician groups were contacted to discuss our observations.

In completing our review, we established a reasonable assurance on the authenticity and accuracy of the computer generated data. Our audit was not directed towards assessing the completeness of the files from which the data was obtained.

For those items tested, we found no instances of noncompliance except for the matters discussed in the FINDINGS AND RECOMMENDATIONS section of this report. With respect to the items not tested, nothing came to our attention to suggest that untested items would produce different results.

Our field work was performed from December 1993 to May 1994 at the HCFA central office in Baltimore, Maryland, the Boston Regional Office of HCFA, the Boston Regional Office of the Office of Inspector General, and all PROs and selected Medicare Contractors in Region I (see EXHIBIT).

The draft report was issued to HCFA on August 30, 1994. The HCFA's written comments, dated October 31, 1994, are appended to this report (see APPENDIX) and are addressed on pages 9 and 10.

FINDINGS AND RECOMMENDATIONS

For ambulatory services performed on the same beneficiary, with the same date of service, one would expect both entities, OPDs and physicians, to use the same procedure code for the same ambulatory surgery. This is not the case. In a review of selected ambulatory surgeries, there is a 23 percent rate of inconsistent procedure coding by the OPD and the physician. Naturally, one would expect a marginal level of error but not the extent to which was identified. The coding differences are not limited to a particular physician specialty. Both OPDs and physicians are responsible for the incorrect coding. Furthermore, there are indications that this condition is a nationwide problem.

These coding differences happen primarily because ineffective communication/ coordination exists between OPDs and physicians, and the present Medicare medical review structure does not provide a focal point, i.e., the PROs, for an encompassing review of OPDs' and physicians' services.

Because reimbursement is dependent on the procedure performed, the effect on the Medicare program is that (1) a significant number of incorrect payments (overpayments and/or underpayments) to both OPDs and/or physicians are made; (2) beneficiaries are making incorrect payments of their 20 percent coinsurance; and (3) data which IICFA may utilize in developing future reimbursement rates are inaccurate.

HIGH RATE OF PROCEDURE CODING DIFFERENCES

We selected 629 out of 2,591 ambulatory surgical cases reviewed by the Region I PROs for the period in our audit. As part of their review function, the PROs use medical records to verify the procedure codes submitted by OPDs. These medical records contain operative notes, pathology results, as well as physicians' notes. We obtained the corresponding physician claims from the carriers and compared these procedure codes to the OPDs' procedure codes. Of the 629 cases, 146 cases or 23 percent involved an inconsistency between OPDs' and physicians' coding of the same ambulatory surgery.

An analysis by physician specialty determined that coding differences are not linked to one particular specialty (see Figure 2).

Of the 146 cases, 75 cases or 51 percent of the coding differences identified fall within three specialties, General Surgery, Gastroenterology, and Urology.

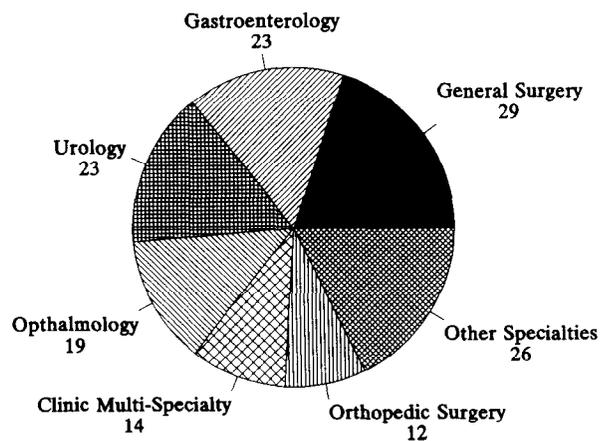


Figure 2 - Summary of the 146 Inconsistencies by Physician Specialty

Furthermore, the coding differences can not be linked to either OPDs or physicians. In 90 cases, the OPD was correct and the physician was wrong. In 28 cases, the opposite is true. In 15 cases, both entities were wrong. Finally, in 13 cases, the PROs could not determine which entity was right or wrong (indeterminable) (see Figure 3).

We were concerned if this condition existed nationwide; therefore, we conducted a computer match between OPD paid claims data and physician paid claims data for the 2-year period 1991 and 1992. For 142,695 ambulatory surgical services, there were 34,350 instances (24 percent) where the ambulatory surgical procedure codes submitted by OPDs were different from the ambulatory surgical procedure codes submitted by physicians.

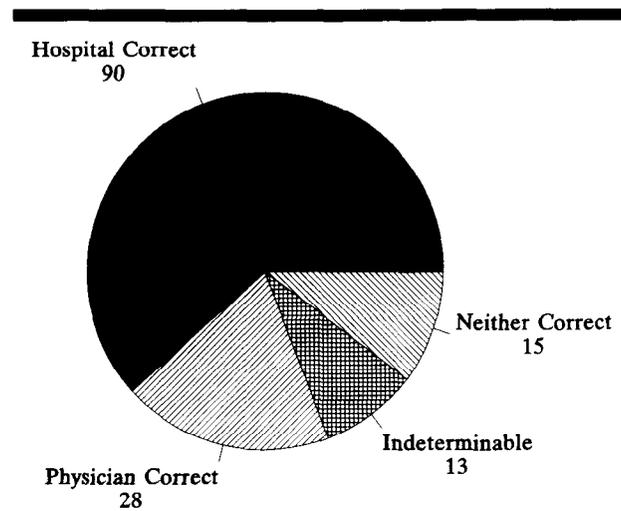


Figure 3 - Who Coded Correctly?

THE EFFECT OF PROCEDURE CODING DIFFERENCES ON THE MEDICARE PROGRAM

The coding of medical services, be it inpatient, ambulatory surgery, or physician services, is emerging as an area of vulnerability. Financially, inaccurate coding of medical services is proving to be costly to the Medicare program. Because reimbursement is dependent upon procedure codes, coding differences result in incorrect reimbursement. For the 146 cases with procedure coding differences, potential incorrect reimbursements¹ of \$1,975 and \$16,650 were made to OPDs and physicians, respectively. Overpayments occurred because (1) the wrong procedure code was used or (2) multiple procedures were claimed when in fact a single procedure was performed. For OPDs, some of the coding differences did not involve an incorrect reimbursement because the correct procedure code fell within the same payment group as the incorrect procedure code. Underpayments occurred because (1) the wrong procedure code was used or (2) either the OPD and/or the physician claimed a single procedure when in fact multiple procedures were performed.

As discussed in the BACKGROUND section of this report, OPDs are reimbursed for ambulatory surgeries through the cost settlement process. For each claim an OPD submits with an ambulatory surgical procedure code, the intermediaries accumulate a predetermined rate, the ASC payment amount, associated with that procedure. At yearend, providers use the total accumulated ASC payment amount for all surgeries performed in preparing their cost reports.

¹ The incorrect reimbursements equal overpayments plus underpayments.

As such, submitting claims with incorrect procedure codes may impact on the accuracy of the cost report. Physicians' reimbursement is also based on a predetermined rate for each procedure code. Depending on the procedure performed and other factors, such as the size of a tumor, physician reimbursement as well as incorrect payments can be significant. The implications of incorrect coding are clearly shown in the following example:

	PROCEDURE CODE	DESCRIPTION	OPD PAYMENT AMOUNT	PHYSICIAN ALLOWED AMOUNT
Hospital	52234	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 to 2.0 cm)	\$363	\$647 ²
Physician	52235	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)	\$417	\$1,100 ²

The description of these procedure codes differs only by the size of the tumor. Because there is an overlap in tumor size (2.0 cm), there is the potential to incorrectly code this procedure. In the above example, there are two possible scenarios. First, the OPD which used procedure code 52234 was correct. If so, the physician who used code 52235 is incorrect and would be overpaid \$453 (\$1,100 - \$647). Conversely, the physician who used code 52235 coded correctly. As a result, the OPD which used code 52234 is incorrect, the amount used to settle the OPD's cost report would be understated by \$54 (\$417 - \$363), and would result in a potential underpayment. This demonstrates how incorrect coding impacts on ones own reimbursement.

With respect to physician services, Medicare beneficiaries are responsible for the 20 percent coinsurance. As such, beneficiaries have been inappropriately charged coinsurance associated with the overpayments or have not met their obligations associated with the underpayments.

Finally, HCFA may rely on this payment data for the development of future payment rates. For example, HCFA is developing a prospective payment system for outpatient care. Utilizing inaccurate data will produce inaccurate payment rates and will result in incorrect reimbursement.

² Allowed amount for a physician in the Boston, Massachusetts area.

REASONS FOR PROCEDURE CODING DIFFERENCES

The differences in the procedure coding of ambulatory surgical services are due to an absence of effective communication/coordination between OPDs and physicians. Specifically, through discussions with OPD personnel and physician billing personnel, differences in coding occur because:

- ▶ physicians' offices do not wait for pathology results (a factor in selecting the procedure code) before submitting a claim, whereas OPDs do;
- ▶ OPDs do not provide nor do physicians request the operative notes for coding purposes; and
- ▶ contradictory or unclear documentation is contained in the medical record about the nature of the procedure performed which precludes proper coding by billing clerks.

In addition, OPDs and physicians stated that specific codes for a particular procedure are not always available or procedure code descriptions are often too similar which causes disagreement between both parties.

The PROs offered the same causes noted above and added:

- ▶ pressure to submit bills as quickly as possible;
- ▶ inexperienced staff skills in CPT-4 coding;
- ▶ incomplete coding (for multiple procedures); and
- ▶ different interpretation of medical records.

Before the causes can be addressed, it is necessary to first identify instances where there is a procedure coding difference between the OPD and the physician. The HCFA currently has under development the MTS. This standard claims processing system will replace 14 different claims processing systems used by Medicare contractors. Furthermore, it will integrate the processing of and serve as a cross check for Medicare Part A and Part B claims. While the MTS is under development, it would be cost effective to design the necessary edits now to identify procedure coding differences. The MTS, however, will begin to be phased-in in 1996 with full implementation in 1998. Interim measures to curb procedure coding differences are needed.

Physicians are presently required to attest to the diagnosis which necessitated an inpatient stay as well as the major procedures performed. Similar attestation could effectively foster communication/coordination between OPDs and physicians in the coding of ambulatory surgeries. Having this attestation prior to the submission of the claims could reduce incorrect reimbursement.

Currently, PROs review a sample of ambulatory surgeries performed in OPDs and the carriers conduct a prepayment and post-payment medical review of physician services. As such, the

Medicare medical review function has a separate review for the nonphysician services (OPD services) and physician services. According to section 1154(a)(1) of the Act, PROs have the authority to review all activities of physicians. Presently, this section of the Act has not been implemented; therefore, there is no focal point for an encompassing review of OPDs' and physicians' services. The HCFA is implementing the "Health Care Quality Improvement Initiative." Under this initiative, PROs will be required to conduct focused reviews and pattern analyses. The memorandum defines pattern analyses as "the examination of aggregated data...to identify the frequency and distribution of conditions, care and outcomes." The memorandum goes on to state, "pattern analysis is an important tool for communicating with hospitals and physicians; a persuasive demonstration that a problem is part of a recurring pattern can be much more persuasive than individual cases." Finally, this initiative is aimed at improving quality of care and protecting the Medicare trust funds.

CONCLUSION

One would expect both parties, OPDs and physicians, to use the same procedure code for the same ambulatory surgery. Based on the results of our review, coding differences exist between OPDs' and physicians' coding of ambulatory surgical procedure codes for the same ambulatory surgery. In fact, there is a 23 percent occurrence rate of procedure coding differences in Region I. Likewise, based on a cursory analysis of nationwide data, there appears to be a 24 percent rate of occurrence. Coding differences are occurring primarily because ineffective communication/coordination exists between OPDs and the physicians; and the lack of an encompassing review of OPDs' and physicians' ambulatory surgical services.

Accurate coding of medical services is essential to maintain the financial integrity of the Medicare program. Detection and prevention of procedure coding differences through the MTS will reduce the vulnerability of coding dependent reimbursement methodologies. Until such time as the MTS is fully operational, it is necessary to bring the provider community together to reduce the costly effects of inaccurate coding.

RECOMMENDATIONS

We are recommending that HCFA implement the following:

- 1) Until such time as the MTS is phased in, foster coordination/ communication between providers so that procedure coding differences are identified prior to submission of claims. This could be achieved by requiring an attestation as to the procedure performed.
 - 2) Require PROs to review the entire episode of care, i.e., OPD claims and physician claims, for pattern analyses.
 - 3) Design an edit for the MTS to identify procedure coding differences between OPD and physician claims and to generate a notice to OPDs and physicians informing them that procedure coding differences have been identified.
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HCFA'S COMMENTS AND OIG RESPONSE

RECOMMENDATION 1

Comments:

The HCFA concurs with the intent of this recommendation. It believes, however, that this recommendation and our second recommendation should be revised to make them consistent with the principles of total quality management that increasingly underlie revisions to the conditions of coverage and payment for facilities and that have given rise to the new PRO scope of work. Specifically, the focus should be on methods to encourage coordination between OPDs and physicians to ensure accurate procedure coding.

The HCFA pointed out that the report lists total overpayments and underpayments. It asked that the OIG compute the net effect to determine if remedying this problem is worth the cost and effort.

Finally, HCFA believes any attestation requirement should follow the recently revised attestation policy for inpatient coding which would be administratively manageable for the providers.

Response:

The OIG would support any initiative that focuses on methods that would encourage coordination/communication between OPDs and physicians to ensure accurate procedure coding. Accordingly, we believe that an attestation requirement which would be administratively manageable for the providers would be the easiest and surest approach to accomplish this.

With respect to the cost-effectiveness of remedying this problem, our analysis of the sampled claims indicated a net effect between the overpayments and underpayments of \$477. Regardless of the net effect, a 23 percent rate of inconsistent procedure coding is too high given that reimbursement is procedure code driven. Moreover, given the numerous providers involved, an analysis of overpayments and underpayments should be made on a per provider basis. In our sample, we noted three scenarios; 1) providers with overpayments only; 2) providers with underpayments only, and 3) providers with a combination of both.

RECOMMENDATION 2

Comments:

The HCFA does not concur with this recommendation. It believes that screening of unified claims files with intermediary or carrier medical review should be substituted for PRO review.

Response:

The OIG supports a medical review of unified claims files. The PROs current statement of work provides for a review of a selected sample of beneficiaries. This PRO work provides the opportunity to assess the condition we've identified of physicians and OPDs billing inconsistent procedure codes for the same procedure. We believe that PROs' reviews could be expanded to encompass the entire episode of care and focus on OPD and physician claims for pattern analyses.

RECOMMENDATION 3

Comments:

The HCFA concurs with this recommendation and expects some type of edit to be installed during the implementation of MTS.

EXHIBIT

**PEER REVIEW ORGANIZATIONS AND MEDICARE INTERMEDIARY/
CARRIER CONTRACTORS VISITED DURING REVIEW**

STATE	PEER REVIEW ORGANIZATIONS	MEDICARE INTERMEDIARY/CARRIER CONTRACTORS
RHODE ISLAND	Health Care Review, Inc. Providence, Rhode Island	Blue Cross/Blue Shield of Rhode Island Providence, Rhode Island
MAINE		Blue Cross of Maine South Portland, Maine Blue Shield of Massachusetts Hingham, Massachusetts
NEW HAMPSHIRE	New Hampshire Foundation For Medical Care Dover, New Hampshire	Blue Cross of New Hampshire Manchester, New Hampshire
VERMONT		Blue Shield of Massachusetts Hingham, Massachusetts
MASSACHUSETTS	Massachusetts Peer Review Organization, Inc. Waltham, Massachusetts	Blue Cross/Blue Shield of Massachusetts Braintree, Massachusetts
CONNECTICUT	Connecticut Peer Review Organization, Inc. Middletown, Connecticut	Aetna Life Insurance Company Hartford, Connecticut The Travelers Companies Meriden, Connecticut



DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

Date **OCT 31 1994**
From **Bruce C. Vladeck** *Bruce Vladeck*
Administrator
Subject **Office of Inspector General Draft Report: "Review of Ambulatory Surgical Services Performed in Hospital Outpatient Departments - Procedure Coding Differences," (A-01-94-00507)**
To **June Gibbs Brown**
Inspector General

We reviewed the subject draft report which determined that both physicians and hospital outpatient departments are responsible for incorrect procedure coding for ambulatory surgical services. Our specific comments are attached for your consideration.

Thank you for the opportunity to review and comment on this report. Please advise us if you would like to discuss our position on the report's recommendations at your earliest convenience.

Attachment

Comments of the Health Care Financing Administration (HCFA)
On Office of Inspector General (OIG) Draft Report:
"Review of Ambulatory Surgical Services Performed
in Hospital Outpatient Departments - Procedure Coding Differences."
(A-01-94-00507)

OIG Recommendation

Until such time as the Medicare Transaction System (MTS) is implemented, foster coordination/communication between providers so that procedure coding differences are identified prior to submission of claims. This could be achieved by requiring an attestation as to the procedure performed.

HCFA Response

HCFA concurs with the intent of the recommendation. However, we believe that this recommendation and recommendation two should be revised to make them consistent with the principles of total quality management that increasingly underlie revisions to the conditions for coverage and payment for facilities and that have given rise to the new Peer Review Organization (PRO) scope of work.

Specifically, the focus should be on methods to encourage physicians and ambulatory surgical centers and outpatient departments (OPDs) to coordinate their efforts so that services are accurately characterized. This could be encouraged primarily by encouraging provider audits of their own medical records activities to improve the accuracy of medical records and the coding of procedures. Facility survey requirements could be looked at to see if changes are needed to provide incentives for improvement. Providers could also be encouraged to provide physician offices with notice as to the procedure codes assigned to the procedures to ensure that any disagreements between facility and physician are resolved.

The report, which includes both overpayments and underpayments, lists total amounts of reimbursement to OPDs and physicians for ambulatory surgeries. Data analysis of the kind employed by OIG could be used to identify areas where focused medical review might provide a cost-effective remedy to the problem. To determine whether this activity is worth the cost and effort, you should recompute the discrepancies and look at the net program exposure due to the errors to determine if changes are needed.

Any attestation requirement should follow the same approach as the recently revised attestation policy for inpatient coding where HCFA worked with industry representatives to develop an approach which would meet the regulatory requirements and would be administratively manageable for the providers.

Page 2

OIG Recommendation

Require PROs to review the entire episode of care; i.e., the OPD claims and physician claims, for pattern analyses.

HCFA Response

We do not concur with this recommendation. We believe it should be eliminated and the concept of review folded into recommendation one. Screening of unified claims files with intermediary or carrier medical review should be substituted for PRO review, which is being discontinued.

OIG Recommendation

Design an edit for MTS to identify procedure coding differences between OPD and physician claims and to generate a notice to OPDs and physicians informing them that procedure coding differences have been identified.

HCFA Response

HCFA concurs that an edit should be installed in MTS that would identify procedure coding differences between providers. The MTS edits and exception work group has identified the need for companion service bill editing. We expect that this specific edit will be installed during implementation of MTS.